**TULLY JR. SR. HIGH MEDICATION AUTHORIZATION FOR SCHOOL YEAR \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Student name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of birth: \_\_\_\_\_\_\_\_\_\_Grade:\_\_\_\_\_\_**

**Please return to school nurses office Attention School Nurse**

**\*\*Emergency Medication\*\* Consent**

Does this student have any allergies? List\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does this student have any chronic health conditions? List \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |
| --- | --- | --- | --- |
| **Name of medication** | **Route/ Dose to be given** | | **Frequency/ Time** |
| Epinephrine Auto Injector | Injected □  0.15 mg □ 0.3 mg | | □  Immediately after exposure  □ Signs/ symptoms of Anaphylaxis |
| Special Instructions: | | | |
| **Name of medication** | | **Route/ Dose to be given** | **Frequency/ Time** |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Inhaler | | Inhaled □  1 puff □ 2 puffs | □  As needed every 4-6 hours  □ \_\_\_\_\_\_Minutes Prior to Exercise |
| Special Instructions: | | | |
| **Name of medication** | | **Route/ Dose to be given** | **Frequency/ Time** |
|  | |  |  |
| Special Instructions: | | | |

**□ I agree that this student can use their medication effectively and may carry and use this medication independently at any school/school sponsored activity. Staff intervention and support is needed only during an emergency. \*\*\*(Students may only carry Emergency Medication)\*\*\***

Medical provider signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/guardian signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The school nurse will store Acetaminophen (Tylenol) 325 mg tablets and Ibuprofen (Advil) 200mg and may administer these medications when they are available during regular school day hours. **If I do not supply medication the school nurse may administer school stock medication, which will not be available on field trips.**

|  |  |  |
| --- | --- | --- |
| **Medication** | **Oral Dose (Choose One)** | **Frequency/ Time** |
| Acetaminophen | □ 325 mg □ 650 mg □ Other \_\_\_\_\_\_\_ | Every 4 to 6 hours as needed |
| Ibuprofen | □ 200 mg □ 400 mg □ Other \_\_\_\_\_\_\_ | Every 6 to 8 hours as needed |

I give permission to the school nurse to administer acetaminophen (Tylenol) or ibuprofen (Motrin) when determined to be needed for headache, pain, menstrual cramps or \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

Medical provider signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/guardian signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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